DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section
License Application
Behavioral Health Service Provider

Section 1: PROVIDER INFORMATION

☐ *INITIAL APPLICATION* ☐ *RENEWAL APPLICATION* ☐ *OTHER* **(Specify)** _____

LICENSE NUMBER _____ *EXPIRATION DATE* _____

**Check & Payment Transmittal Form must be submitted to DHH Licensing Fee, PO Box 62949, New Orleans, LA 70162-2949*

TOTAL FEE AMOUNT INCLUDED _____ *CHECK / MONEY ORDER #* _____

STATE ID #BH___ ___ ___ ___ ___ ___ ___

FACILITY (DBA) NAME _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ *FAX NUMBER* (____) _____ *EMAIL ADDRESS*_____

**MAILING ADDRESS (IF DIFFERENT)* _____

CITY / STATE / ZIP _____

HOURS OF OPERATION _____

MONDAY	*TUESDAY*	*WEDNESDAY*	*THURSDAY*	*FRIDAY*	*SATURDAY*	*SUNDAY*

ADMINISTRATOR _____ **Direct Phone# (not voicemail)** _____ **Email** _____

CLINICAL SERVICES DIRECTOR _____

*****CLINICAL SUPERVISOR** *(required for opioid treatment programs)* _____

Is this facility located on the campus or in the building of another healthcare facility?

☐ *No* ☐ *Yes* *If yes, list the name and state ID# of the other healthcare facility:* _____

Accredited? ☐ *No* ☐ *Yes*: *Accrediting organization:* _____ *Expiration date:* _____

Section 2: TYPE OF FACILITY/PROVIDER

TYPE OF SERVICE: ☐ *Substance Abuse/Addiction only* ☐ *Mental Health only* ☐ *Both*

POPULATION SERVED: ☐ *Adults (18+)* ☐ *Adolescent (13-17yo)* ☐ *Children (under13)*

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-0157 • http://new.dhh.louisiana.gov/healthstandards

BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

TYPE of facility and TREATMENT PROGRAMS:

☐ ***INPATIENT / RESIDENTIAL FACILITY***

- ☐ ***Clinically Managed Low-Intensity Residential Treatment Program (Halfway House) (ASAM Level III.1)***
- ☐ ***Clinically Managed Medium-Intensity Residential Treatment Program (adult only ASAM Level III.3)***
- ☐ ***Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)***
- ☐ ***Clinically Managed Residential Detoxification Program (Social Detoxification ASAM Level III.2D)***
- ☐ ***Medically Monitored Intensive Residential Treatment Program (adult only ASAM Level III.7)***
- ☐ ***Medically Managed Residential Detoxification (Medically Supported Detoxification- adult only- ASAM Level III.7D)*** *(must be approved by OBH)*
- ☐ ***Mothers with Dependent Children Program (Dependent Care Program)***

NUMBER OF LICENSED UNITS (Bedrooms) _____ ***NUMBER OF LICENSED BEDS*** _____

☐ **OUTPATIENT FACILITY**

- ☐ ***Mental Health Services Program***
- ☐ ***Psychosocial Rehabilitation Services Program -formerly Mental Health Rehabilitation***
- ☐ ***Crisis Intervention Program***
- ☐ ***Community Psychiatric Support and Treatment Program***
- ☐ ***Home And Community Mental Health Services Program***
- ☐ ***Addiction Outpatient Treatment Program (ASAM Level I)***
- ☐ ***Ambulatory Detoxification with Extended on-site monitoring Program (ASAM Level II-D)***
- ☐ ***Intensive Outpatient Treatment Program (ASAM Level II.1)***
- ☐ ***Opioid Treatment Program (must have Facility Need Assessment by OBH)*** ***FNA approval date*** _____

☐ **HOME and/or COMMUNITY SERVICES PROGRAM See §5601.(E)(14)(b)**

- ☐ ***Psychosocial Rehabilitation Services Program***
- ☐ ***Crisis Intervention Program***
- ☐ ***Community Psychiatric Support and Treatment Program***
- ☐ ***Mental Health Services Program***

Section 3: TYPE OF OWNERSHIP

NON- PROFIT	FOR – PROFIT	GOVERNMENT
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *FEDERAL* ☐ *HUMAN SVCS DISTRICT/ AUTHORITY*
☐ *CORPORATION* ☐ *LLC*	☐ *CORPORATION* ☐ *RELIGIOUS AFFILIATION*	☐ *CITY*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *CITY/PARISH*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE* ☐ *UNINCORPORATED ASSOCIATION*	☐ *HOSPITAL DISTRICT*
☐ *UNINCORPORATED ASSOCIATION*	☐ *LLC*	☐ *COMBINATION GOV-N-PROFIT*
☐ *OTHER (Specify):* _____	☐ *OTHER (Specify):* _____	☐ *OTHER (Specify)* _____

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BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

LEGAL ENTITY / CORPORATION NAME _____ *EIN#* _____

ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (_____) _____ *FAX NUMBER (_____)* _____

If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	*ADDRESS*	*TELEPHONE NUMBER*

Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ *Yes* ☐ *No*
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other providers.

Owner	*Facility Name*	*Facility Address*	*Provider #, LIC.#, or State ID#*

Has there been a change of ownership or control within the last year? ☐ *Yes* ☐ *No* *If yes, give date:*_____

Section 4: OFF-SITE INFORMATION *(attach addendum A's for each offsite listed below)*

INDICATE THE NAME, ADDRESS, CITY, STATE, ZIP, PARISH, AND TELEPHONE NUMBER OF EACH OFF-SITE CAMPUS

OFF-SITE NAME	*GEOGRAPHICAL ADDRESS* (Street, City, State, & Zip Code)	*PARISH*	*TELEPHONE NUMBER*	*LICENSE NUMBER*
1.				
2.				
3.				
4.				

Section 5: ATTESTATION & SIGNATURE

***ATTESTATION** (Read carefully):*
I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

_____
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____
AUTHORIZED REPRESENTATIVE SIGNATURE *DATE*

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BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

OFF-SITE ADDENDUM A

OFF-SITE NAME	*LICENSE #*	*ADDRESS OF OFFSITE*	*PARISH*	*TELEPHONE NUMBER*

************See §5605.(G.) regarding Off-Sites *************

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☐ **HOME and/or COMMUNITY SERVICES PROGRAM See §5601.(E)(14)(b)**

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- ☐ ***Crisis Intervention Program***
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- ☐ ***Mental Health Services Program***

********Make copies of this addendum as needed for each offsite*********

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